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# Transcript of Open Session - Meeting

**Date:** November 5, 2020

**Case:** State of Illinois Health Facilities and Services Review Board

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH  
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION - MEETING

Held Virtually

Thursday, November 5, 2020

9:12 a.m. CST

BOARD MEMBERS PRESENT:

DEBRA SAVAGE, Chairwoman

STACY GRUNDY

GARY KAATZ

SANDRA MARTELL

LINDA RAY MURRAY

Job No. 257116

Pages: 1 - 78

Reported by: Paula Quetsch, CSR, RPR

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1 ALSO PRESENT:

2 COURTNEY AVERY, Administrator

3 MICHAEL CONSTANTINO, IDPH Staff

4 ANN GUILD, Compliance Manager

5 GEORGE ROATE, IDPH Staff

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1 P R O C E E D I N G S

2 CHAIRWOMAN SAVAGE: All right. Well, we're  
3 going to go ahead and get started. This is my gavel.

4 Okay. The first thing I would like to do  
5 for our State Board staff meeting is to honor  
6 Senator Deanna Demuzio. Senator Demuzio has been  
7 on our Health Facilities State Board since 2012 and  
8 unfortunately recently passed away. She is a  
9 dedicated public servant -- or she was a dedicated  
10 public servant to the State of Illinois and her  
11 community. At this moment I'd like to take a  
12 moment of silence in honor of Senator Demuzio.

13 (Moment of silence.)

14 CHAIRWOMAN SAVAGE: And we thank her for  
15 her service and may her memory be a blessing  
16 to all.

17 So hopefully everybody has your agenda.  
18 May I have a motion to approve our agenda?

19 (Inaudible.)

20 CHAIRWOMAN SAVAGE: Okay. So Gary Kaatz  
21 has been the first. May I have a second?

22 MEMBER GRUNDY: Second.

23 CHAIRWOMAN SAVAGE: Second by Stacy Grundy.  
24 Thank you.

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1           Now may I have an approval of our transcripts  
2 from our September 22nd, 2020, meeting?

3           MEMBER MARTELL: I so move.

4           CHAIRWOMAN SAVAGE: Thank you, Dr. Martell.

5           MEMBER MURRAY: Second.

6           CHAIRWOMAN SAVAGE: Second by Dr. Murray.

7           Mr. Constantino, can you please read into  
8 the record the items approved by me, the Chairwoman?

9           MR. ROATE: Thank you, Debi. I'm going to  
10 step in for Mike today. He's got a little bit of  
11 a sore throat.

12           Items approved by the Chairwoman are as  
13 follows:

14           Permit Renewal: #19-049 CGH Medical Center,  
15 Sterling, 6-Month Renewal.

16           Permit Renewal: #17-001 Mercyhealth Crystal  
17 Lake Medical Office Building, 39-month renewal.

18           Permit Renewal: #17-002 Mercyhealth  
19 Crystal Lake Hospital, 39-month renewal.

20           Permit Alteration: #180-16 Transformative  
21 Health of McHenry to alter the source of the funds  
22 for the project.

23           Exemption E-042-20, Rush Oak Park Hospital to  
24 discontinue a 36-bed long-term care bed category

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1 of service.

2 E-043-20, Community Care Center to approve  
3 the change of ownership.

4 E-044-20, Swedish Hospital to discontinue  
5 an 18-bed long-term care bed category of service.

6 And finally, E-045-20, Kindred Hospital of  
7 Peoria for a change of ownership.

8 CHAIRWOMAN SAVAGE: Thank you, George.

9 One second, please.

10 MS. AVERY: Mike or George, can you see  
11 anybody? We're looking for the general public. I  
12 can't see anyone.

13 MR. ROATE: I have a call-in user 6; I  
14 have a D-E-L-D-D-I-B.

15 MS. AVERY: Okay. I can see it on Debi's.  
16 Thank you.

17 CHAIRWOMAN SAVAGE: Next we will have  
18 public participation -- oh, I'm sorry -- George,  
19 first, could you please do our roll call.

20 MR. ROATE: Yes.

21 Stacy Grundy.

22 MEMBER GRUNDY: Here.

23 MR. ROATE: Gary Kaatz.

24 MS. AVERY: Gary?

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1 MR. ROATE: Mr. Kaatz.

2 MS. AVERY: He's here.

3 MR. ROATE: Okay.

4 Sandra Martell.

5 MEMBER MARTELL: Present.

6 MR. ROATE: Thank you.

7 Linda Ray Murray.

8 MEMBER MURRAY: Present.

9 MR. ROATE: Thank you.

10 And Chairwoman Savage.

11 CHAIRWOMAN SAVAGE: Present.

12 MR. ROATE: Five board members in attendance.

13 CHAIRWOMAN SAVAGE: Thank you.

14 Okay. Now we will have public

15 participation, and we believe we have Dr. Chopra

16 on the phone, if you could unmute him, please.

17 All right. Dr. Chopra, if you could be

18 sworn in by our court reporter, please.

19 DR. CHOPRA: Sure. I'm not able to hear

20 the court reporter:

21 CHAIRWOMAN SAVAGE: Hold on just a moment,

22 Dr. Chopra.

23 Whoever is our court reporter, can you

24 please make yourself known.

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1           One moment while we find our court reporter.

2           (An off-the-record discussion was held.)

3           (Witness sworn.)

4           CHAIRWOMAN SAVAGE: Okay. Dr. Chopra, go  
5 ahead. You have two minutes.

6           DR. CHOPRA: Thank you. I'm an endovascular  
7 specialist and interventional radiologist in the  
8 Chicagoland area. I've been serving patients in  
9 the community on the south side for almost over a  
10 decade -- actually, almost two decades. I've  
11 served as chairman of radiology and am an attending  
12 associate professor still at Rush University.

13           And one of the challenges we have with our  
14 patient population, especially with Mercy Hospital  
15 closing, this population is at high risk for  
16 diabetes, and they can end up with a lot of  
17 peripheral arterial disease as well as on dialysis,  
18 and they lead to amputations. This decreases  
19 their life span and also increases morbidity. So  
20 the quality of life decreases, and also a very  
21 heavy on burden cost of the health system.

22           We've been now performing a lot of these  
23 procedures as outpatients, same day. The principle  
24 is to do it better, faster, cheaper, prevent the

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1 amputations. Now with Mercy Hospital closing the  
2 challenge has been where will these patients go.  
3 So we've been identifying outpatient facilities to  
4 do this. I'm also at Jackson Park Hospital; I've  
5 been at Rosalind Hospital, Advocate Trinity  
6 Hospital. We go to about 30-some nursing homes,  
7 and the elderly are very vulnerable, especially  
8 now with the COVID era where these patients, to  
9 get them into a hospital is also tougher. So  
10 we've been working very hard and are now able to  
11 serve these patients on an outpatient basis in a  
12 very safe environment and get them in and out the  
13 same day, and it's much better; it's faster for  
14 the patient and definitely much cheaper for both  
15 the health system, the patient, and the community.

16 I'd be happy to take any questions, or I  
17 could just keep talking.

18 CHAIRWOMAN SAVAGE: Thank you so much,  
19 Dr. Chopra.

20 Is there anyone else here for public  
21 participation? If so, raise your hand.

22 (No response.)

23 CHAIRWOMAN SAVAGE: Okay. Hearing none.

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1 CHAIRWOMAN SAVAGE: So next on the agenda  
2 we have a permit to establish the Michigan Avenue  
3 Center for Health Multispecialty ASTC, Project H-01.

4 Mike, can we have the State Board staff  
5 report?

6 MR. ROATE: Thank you, Madam Chair. The  
7 applicant Michigan Avenue Center for Health, Ltd.,  
8 and Michigan Avenue Health Systems, Ltd., propose  
9 to establish a multispecialty ambulatory surgical  
10 treatment center located at 2415 South Michigan  
11 Avenue, Chicago, Illinois.

12 The cost of the project is \$2,135,746, and  
13 the expected project completion date is the  
14 December 31st, 2021.

15 Board staff found the project to be  
16 not in conformance with three items in the  
17 1110 criteria, that being geographical service area  
18 need, service accessibility, and unnecessary  
19 duplication/maldistribution of service.

20 Thank you, Madam Chair.

21 CHAIRWOMAN SAVAGE: Okay. Thank you very  
22 much, George.

23 Now, may I have a motion to approve this  
24 permit for the Michigan Avenue Center for Health

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1 Multispecialty ASTC? May I have a motion?

2 MEMBER MARTELL: I so move.

3 CHAIRWOMAN SAVAGE: Thank you, Dr. Martell.

4 May I have a second?

5 MEMBER GRUNDY: I second.

6 CHAIRWOMAN SAVAGE: Thank you,  
7 Stacy Grundy.

8 MS. AVERY: Is there anyone to present on  
9 behalf of Project 20-025? Please raise your hand.  
10 Anne Cooper and you may proceed.

11 MS. COOPER: Vera Schmidt should also be  
12 on the line, as well.

13 MS. AVERY: What was the other name?

14 MS. COOPER: Vera Schmidt.

15 MS. AVERY: I don't see Vera -- oh, I do.  
16 Okay. Sorry. Please proceed.

17 (Witnesses sworn.)

18 CHAIRWOMAN SAVAGE: Okay. Go ahead, Anne  
19 and Vera.

20 MS. COOPER: Is Vera on?

21 CHAIRWOMAN SAVAGE: I heard her before.

22 She was on.

23 MS. COOPER: I did, as well.

24 CHAIRWOMAN SAVAGE: Do you see her, George?

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1 MR. ROATE: I see her on the attendee list.  
2 Okay. She's just been taken off mute.

3 MS. SCHMIDT: Yes. Can you hear me?

4 MR. ROATE: Yes, ma'am.

5 MS. SCHMIDT: Good morning. I'm Vera  
6 Schmidt. I'm the chief of operations of Michigan  
7 Avenue Center for Health. With me today I have  
8 our CON attorney Anne Cooper.

9 First of all, I'd like to thank the Board  
10 staff for its thorough assessment of this planned  
11 surgery center and the generally positive State  
12 Board report.

13 This project was conceived this spring to  
14 address health care disparities on Chicago's south  
15 side. Subsequent to filing of our application in  
16 May, Mercy Hospital and Medical Center announced  
17 its plan to discontinue its 412-bed hospital by  
18 May 2021. Given the impending discontinuation of  
19 Mercy, this project is needed more than ever to  
20 address the gaps in care that will result in the  
21 wake of the cessation of health care services at  
22 Mercy.

23 Michigan Avenue Center for Health is  
24 located at 2415 South Michigan Avenue, less than a

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1 quarter of a mile from Mercy. Like many parts of  
2 the City of Chicago, the community proposed to be  
3 served by this surgery center is economically  
4 disadvantaged with 25 percent of the population  
5 living below the Federal poverty limit compared to  
6 17 percent in the remainder of the City and  
7 12 percent statewide. It also consists of  
8 significant minority populations, which are  
9 30 percent African-American, 33 percent Hispanic,  
10 and 5 percent Asian. Due to these factors and  
11 despite the presence of a large medical center in  
12 the community, it is a federally designated  
13 medically underserved population and medically  
14 underserved area.

15 Historically, Mercy performed a total of  
16 2,750 outpatient surgical cases. Of these cases,  
17 over 400 were OB/GYN procedures, and 500 were pain  
18 management, two of the specialties proposed at  
19 Michigan Avenue Center for Health. During the  
20 recent public hearings on the Mercy discontinuation,  
21 many patients expressed concern as to where they  
22 would receive healthcare services once Mercy closes  
23 next year and how they would get there, particularly  
24 those who are reliant on public transportation.

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1           Importantly, while Mercy plans to develop  
2 a care center that will offer diagnostics, urgent  
3 care, and care coordination, there is no plan to  
4 provide outpatient surgical care. Accordingly,  
5 patients who normally have outpatient procedures  
6 performed at Mercy will need to travel farther for  
7 surgical care if this project is not approved.

8           I would like to briefly address the  
9 negative findings for this project.

10           Geographic service area need. While the  
11 physicians associated with this project have not  
12 historically referred a majority of patients from  
13 within the 10-mile geographic service area, we  
14 anticipate with the discontinuation of Mercy, we  
15 will serve a larger percentage of patients from  
16 the immediate area. Further, we will have an open  
17 medical staff, so physicians who have historically  
18 performed cases at Mercy can perform their cases  
19 at our surgical center.

20           Service accessibility and unnecessary  
21 duplication/maldistribution of service. Both of  
22 these criteria are based on the fact that existing  
23 hospitals and surgery centers within a 10-mile  
24 geographic service area operate below the State's

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1 80 percent utilization standard.

2 Utilizing hospitals for procedures that  
3 can safely be performed in an outpatient surgery  
4 center is not an efficient use of scarce health  
5 care resources. Escalation of health care costs  
6 have largely been attributed to high prices  
7 charged by hospitals. Of the 13 surgery centers  
8 located within 10 miles of Michigan Avenue Center  
9 for Health, six are operating at or above the  
10 State Standard, four are not approved for obstetrics,  
11 and the remaining three surgery centers (Grand  
12 Avenue Surgicenter, River North Surgery Center,  
13 and Western Diversey Surgery Center), provide  
14 little to no care for Medicaid patients and are  
15 located on the near north and north side of  
16 Chicago, which presents a hardship for many  
17 patients who lack access to transportation and are  
18 reliant on family and friends to transport them to  
19 their medical appointments.

20 Finally, Michigan Avenue Center for Health  
21 is committed to improve health care to patients  
22 residing on the south side of Chicago who face  
23 various barriers to access health care. We will  
24 have an open medical staff and will add surgical

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1 specialties to address the needs of the community  
2 as necessary.

3 Historically, over 30 percent of the patients  
4 we have served are Medicaid beneficiaries.  
5 However, we treated these patients as charity care  
6 and did not charge them or the State Medicaid  
7 program for services. Going forward, Michigan  
8 Avenue Center for Health will be Medicare and  
9 Medicaid certified and will accept all patients  
10 who are appropriate for outpatient surgery regardless  
11 of race, color, national origin, gender, sexual  
12 orientation, age, religion, disability, or payor  
13 source. We anticipate over 30 percent of patients  
14 will be Medicare, Medicaid, or uninsured.

15 Further, we understand many patients work  
16 essential jobs and cannot take time off during the  
17 week, so to accommodate patients' work schedules,  
18 we will allow patients to schedule procedures on  
19 Saturdays and Sundays, as needed. Our extended  
20 hours will provide more flexibility so patients  
21 can minimize time off from work, thereby making  
22 health care more accessible to low-income patients.

23 Michigan Avenue Center for Health is needed  
24 now more than ever to address healthcare disparities

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1 on the south side of Chicago, which will become  
2 even more stark with the discontinuation of Mercy  
3 Hospital and medical center.

4 Thank you for your time. We respectfully  
5 ask that the Board approve this project to improve  
6 access to healthcare on Chicago's south side. I'd  
7 be happy to answer any questions that the Board  
8 may have.

9 CHAIRWOMAN SAVAGE: Do the Board members  
10 have any questions?

11 MEMBER KAATZ: (Inaudible.)

12 CHAIRWOMAN SAVAGE: Mr. Kaatz, can you  
13 repeat your question? I'm so sorry.

14 MS. AVERY: This is only to the  
15 presenters. He was in public participation.

16 MEMBER KAATZ: Okay.

17 CHAIRWOMAN SAVAGE: I'll rephrase my  
18 question. Does anyone have any questions for  
19 Anne Cooper and Vera Schmidt?

20 MEMBER MURRAY: I have a question.

21 CHAIRWOMAN SAVAGE: Thank you, Dr. Murray.

22 MEMBER MURRAY: So I didn't really hear an  
23 attempt to answer the position from the staff that  
24 this service appears to duplicate services and

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1 doesn't meet the criteria that's listed in the  
2 report.

3 MS. COOPER: So we did -- basically,  
4 there's -- there are hospitals within 10 minutes  
5 of the proposed Michigan Avenue Center for Health,  
6 and because of hospitals being much more expensive  
7 places of service, Medicare rates are almost twice  
8 in a hospital outpatient department than they are  
9 in an outpatient surgery center, so we don't think  
10 that the hospitals are really good locations for  
11 the procedures to be performed particularly given  
12 that we're talking about a patient population that  
13 is -- has a high -- is low-income, economically  
14 disadvantaged.

15 There are 16 surgery centers within 10 miles  
16 and -- I apologize; I need to look at my notes --  
17 six are operating above the State -- so of the 13,  
18 six are operating above the State standard, four of  
19 them are not approved for obstetrics, and then the  
20 other three surgery centers, which are Grand Avenue,  
21 River North, and Northwestern, provide almost -- I  
22 think only one of those surgery centers provided any  
23 Medicare care, and I think it was like one patient  
24 in 2019.

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1           Given that one of the purposes of this  
2 project is to serve a large percentage of Medicaid  
3 population and underserved individuals, those  
4 aren't surgery centers. So we didn't really feel  
5 there's any hospital or surgery center within the  
6 10-mile service area that can adequately address  
7 the needs of this community.

8           And the other issue, too, a lot of the  
9 patients that use the outpatient services at Mercy  
10 either walk or take public transportation, and one  
11 woman in particular mentioned, you know, she  
12 already takes two buses to get to Mercy, and for  
13 them to have to travel to the north side -- and  
14 she had expressed sort of concern about having to  
15 take more than two buses, I would also note that  
16 Michigan Avenue is located right next to a bus  
17 stop. So it would be much easier for patients to  
18 get to Michigan Avenue than it would be to those  
19 three surgery centers that offer obstetrics on the  
20 north side.

21           MEMBER GRUNDY: I have a question, as well.

22           I know I saw we got a list of, I guess the  
23 hospitals and the 13 surgery centers within a  
24 10-mile radius, but in the report it said that, I

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1 guess only one of three accept Medicaid services.  
2 So out of the 13 that are listed in the 10-mile  
3 radius, are you saying that -- how many of those --  
4 are you saying only three of those accept Medicaid?

5 MS. COOPER: No, of the three that offer  
6 obstetrics, only one of the three is Medicaid.

7 CHAIRWOMAN SAVAGE: I do have a question,  
8 as well.

9 So in relation to your physicians, it was  
10 that you didn't have any physicians from Mercy  
11 Hospital. Have you talked with them to try to get  
12 them on board given the situation there?

13 MS. SCHMIDT: I think we will. We applied  
14 for -- this application was before the announcement  
15 of Mercy closing, but everyone in the community  
16 knew that this may be happening. We've been  
17 approached by other physicians to utilize their  
18 facility for some outpatient procedure. Dr. Chopra  
19 who had spoken earlier mentioned this would be a  
20 great location for him. I don't know -- I don't  
21 think he necessarily has patients coming from  
22 Mercy, but he does see patients in this area.

23 CHAIRWOMAN SAVAGE: Okay. Thank you.

24 Do any of our other Board members or State

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1 Board staff have any questions?

2 MEMBER MARTELL: It's more of a procedural  
3 question.

4 CHAIRWOMAN SAVAGE: Hold on, Gary.  
5 Go ahead.

6 MEMBER MARTELL: Again, kind of taking a  
7 look, I mean, because there was new information  
8 that would have come out afterwards regarding the  
9 closure of Mercy and probably a recalculation of  
10 referral resources, what are the provisions then  
11 from a staff -- a State staff report -- I'm sorry?

12 CHAIRWOMAN SAVAGE: It's a tongue tie, yes.  
13 George or Mike, can you speak to that?

14 MR. ROATE: As far as the information that  
15 was -- any of the information that could be  
16 gleaned from the closure of Mercy Medical Center,  
17 the applicants are welcome to supply that at a  
18 later date. They have an option to defer if  
19 they'd like to add that to the report and possibly  
20 affect the findings. That's entirely up to them  
21 at this point and entirely up to the Board to make  
22 a decision whether they'd like to defer or not.

23 CHAIRWOMAN SAVAGE: And, Mr. Kaatz, did  
24 you have a question? Yes, please. Dr. Chopra is

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1 not a presenter. He was public participation.

2 MEMBER MURRAY: Let me ask another question  
3 to set up --

4 CHAIRWOMAN SAVAGE: Hold on, Dr. Murray.  
5 Mr. Kaatz is speaking.

6 MEMBER MURRAY: Oh, I'm sorry. I can't  
7 hear him.

8 CHAIRWOMAN SAVAGE: Go ahead, Mr. Kaatz.

9 MEMBER KAATZ: First of all, is Dr. Chopra  
10 a fellowship-trained, board-certified interventional  
11 radiologist?

12 MS. SCHMIDT: That is correct, Dr. Chopra  
13 is a board-trained interventional radiologist.

14 MEMBER KAATZ: I believe I understand the  
15 description of the project, but for that level of  
16 interventional radiology I think you need biplane  
17 system imaging, and a biplane system is about  
18 \$3 million, so I'm curious how you're going to be  
19 able to do interventional radiology without  
20 biplane system imaging in the facility.

21 MS. SCHMIDT: You know what? I'm sorry;  
22 I'm not familiar with that procedure. I do know  
23 that the facility does have a (indiscernible)  
24 table and all the other things that are needed

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1 for -- can you hear me okay?

2 THE COURT REPORTER: Not really.

3 MEMBER KAATZ: And then my last question  
4 is, Dr. Chopra, I see his main hospital privileges  
5 are in Gottlieb Hospital, and, boy, that's a long  
6 distance from where this project is located.

7 CHAIRWOMAN SAVAGE: Anne, can you address  
8 that, or Vera?

9 MS. COOPER: He also serves patients in  
10 Jackson Park, and I believe he also had offices  
11 located on the south side of Chicago. Even though  
12 he has admitting privileges at Gottlieb, he does  
13 have offices in -- on the south side.

14 MEMBER KAATZ: Okay. He mentioned that he  
15 was on the staff at Rush. Does he not have any  
16 privileges at Rush?

17 MS. COOPER: I can't speak to that. Vera --  
18 I don't know. Vera, I don't know if you know.

19 Is Vera on the line still?

20 MS. AVERY: Vera is on.

21 CHAIRWOMAN SAVAGE: Vera is on somewhere.

22 MS. SCHMIDT: I don't know his status  
23 at Rush.

24 MEMBER KAATZ: Okay. I asked the question

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1 because he mentioned that he was an associate  
2 professor there.

3 My last question is, what do you have in  
4 the plans if something goes wrong here? What if you  
5 get a surprise hemorrhaging, other complications?  
6 What are you going to do at this location? What  
7 are your plans? What do you have in place?

8 MS. SCHMIDT: What we have in place is  
9 that we try to obviously manage the condition at  
10 the facility, and if not, we have to transfer and  
11 would have to decide what hospital would be the  
12 closest hospital for a transfer.

13 MEMBER KAATZ: And are you going to be  
14 administering anesthesia at this facility?

15 MS. SCHMIDT: Yes, we're going to do  
16 MAC-monitored anesthesia care.

17 MEMBER KAATZ: Who is going to be responsible  
18 for that? Is that an anesthesiologist?

19 MS. SCHMIDT: Yes, an anesthesiologist.

20 CHAIRWOMAN SAVAGE: Did you have a  
21 question, Dr. Murray?

22 MEMBER MURRAY: Yes, I did. It's a  
23 question to the presenter, but also, let me just  
24 put it out there for our Board to consider.

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1           So here we have a situation where we know  
2 a public -- a major hospital is discussing closure,  
3 plans to close. We also are in the midst of a  
4 global pandemic. So I've already mentioned at  
5 several meetings I'm concerned about how our  
6 criteria are -- how can I say this nicely -- out  
7 of date, and we don't really have a easy mechanism  
8 to revise them.

9           So one of the factors that goes in here is  
10 what we think is going to happen over the next few  
11 years -- and let me emphasize a few years; I'm not  
12 talking about a few months -- with COVID and the  
13 ability of our inpatient facilities to flex their  
14 staff and work to cover what we normally would  
15 consider routine procedures that contemplate would  
16 be handled by a facility like this.

17           So my first question is whether the  
18 presenters and the applicant might want to consider  
19 a revision to their application taking into  
20 account some of these factors, especially the  
21 closing of Mercy but also the general situation  
22 that's going on, ability to have inpatient  
23 procedures.

24           So that's one question to them. But my

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1 question for the rest of us is, again, we have to  
2 have an agenda and a time for us to discuss all  
3 these other issues in terms of how we evaluate  
4 this kind of application.

5 CHAIRWOMAN SAVAGE: Go ahead, Anne and Vera.

6 MS. COOPER: With respect to the issue  
7 with the pandemic, which like I said, I think  
8 everybody is -- all the public health officials  
9 that I've kind of been listening to indicate that  
10 we're not really going to be out of the woods  
11 until sometime next year, maybe 2022. And with  
12 the COVID cases spiking right now, and with  
13 hospitals, you know, getting overwhelmed with  
14 COVID-related patients as cases spike, hospitals  
15 are going to have to once again postpone elective  
16 surgeries.

17 These procedures that are being performed  
18 at Michigan Avenue are technically elective  
19 procedures, but that having been said, sometimes  
20 an elective procedure, while it's not emergent, a  
21 patient really can't put it off for multiple  
22 months because their condition may continue to  
23 deteriorate over that time.

24 So I think that a surgery center like

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1 Michigan Avenue will actually assist with the COVID  
2 issues where we can take some of those patients  
3 that cannot be seen in a hospital setting and take  
4 them in a safe setting which is a small facility  
5 with no restrictions. You won't have to worry  
6 about any issues with cross-contamination with  
7 COVID. So I think a facility such as Michigan  
8 Avenue will be beneficial to the healthcare system  
9 in light of the pandemic that we see ourselves  
10 currently in.

11 CHAIRWOMAN SAVAGE: Thank you.

12 Any other questions from the Board or the  
13 staff?

14 (No response.)

15 CHAIRWOMAN SAVAGE: Okay. George -- oh,  
16 I'm sorry -- Mike, were you saying something?

17 MR. CONSTANTINO: I'm just curious.  
18 30 percent Medicaid, are you going to be able to  
19 hit that target that you're telling the Board that  
20 you're going to provide?

21 MS. SCHMIDT: Yes, between Medicare,  
22 Medicaid, or uninsured or charity care.

23 MR. CONSTANTINO: No. You had told us  
24 that it was going to be 30 percent Medicaid and

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1 5.-something charity care. Is that correct?

2 MS. SCHMIDT: Let me take a look at my notes.

3 MS. COOPER: I mean, historically that's  
4 what Michigan Avenue has provided. Over the last  
5 several years it's been about 30 percent, they've  
6 treated about 30 percent Medicaid patients.

7 MR. CONSTANTINO: I don't have anything to  
8 confirm that, Anne, because they weren't licensed  
9 as an ASC before now. It was our understanding,  
10 it was the staff's understanding that your intent  
11 was to provide 30 percent Medicare -- care of  
12 30 percent Medicaid patients. Is that still  
13 the case?

14 MS. SCHMIDT: Anne, are you there?

15 MS. COOPER: Yes, I am.

16 MS. SCHMIDT: Historically we've seen  
17 these Medicaid patients. And you're right,  
18 because there's no license you wouldn't have that  
19 data. I can just tell you that's the number of  
20 patients that we had seen. Actually, it could be  
21 even more.

22 MR. CONSTANTINO: And that's what you're  
23 intending to do here?

24 MS. SCHMIDT: Once we receive Medicare and

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1 Medicare certification, then we can continue that  
2 volume.

3 MR. CONSTANTINO: Once licensed how long  
4 do you think it's going to take to get Medicaid/  
5 Medicare certified?

6 MS. COOPER: I can speak to -- because  
7 it's a new application for Medicare, it's going to  
8 take probably 9 to 12 months.

9 MS. SCHMIDT: I agree.

10 MS. COOPER: That's how long it takes to  
11 get a new facility Medicare certified, and because  
12 it's a new application, they generally go to kind  
13 of the bottom of the list. But like you have to  
14 go through -- once you submit your application,  
15 the Medicare contractor has 60 days to review.  
16 Then it goes to the State agency, which in this  
17 case is IDPH, and they do their review, and they  
18 have about 60 days. Then it goes to the Central  
19 Office, and they have, you know, 60 or so days to  
20 review. And plus, you have to schedule a survey  
21 during that period of time.

22 So it's going to probably take, you know,  
23 9 to 12 months just because I don't know how  
24 backlogged IDPH or Medicare is in terms of

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1 COVID-related issues.

2 MR. CONSTANTINO: So they're not going to  
3 rely on the certification you already had done?

4 MS. COOPER: It's not Medicare certified,  
5 I don't believe.

6 MS. SCHMIDT: No, the facility has to be  
7 licensed and accredited in order to be done.

8 CHAIRWOMAN SAVAGE: Go ahead, Dr. Martell.

9 MEMBER MARTELL: In kind of looking at, as  
10 well -- of course, the data is based on historical  
11 procedures. I also looked at, you know, in terms  
12 of referral resource the OB/GYN coming from the  
13 Access Community Health Network it looked like  
14 from the FQHCs. Are there any more formal  
15 commitments for referral for what would be  
16 ASC-type procedures from them?

17 MS. SCHMIDT: I'm not sure I understand  
18 the question. Could you help me, Anne?

19 MS. COOPER: Are you asking if the FQHCs  
20 are going to be a referral source for this project?

21 MEMBER MARTELL: Correct. Because I look  
22 at the OB/GYN procedures that are being referred,  
23 and they're coming predominantly -- you know,  
24 we've got, again, what we know the historical

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1 provision was by Access Health Center with  
2 Dr. Goyal and Dr. Ventura.

3 MS. COOPER: I think that that's a correct  
4 statement that they will continue to come from  
5 those types of facilities, but Vera can expand  
6 on that.

7 MS. SCHMIDT: I think when they gave us  
8 those referrals, I remember speaking to them about  
9 it, those numbers are -- those patients were the  
10 ones that were located close to the south side of  
11 Chicago close to Michigan Avenue Center for Health.

12 So Access is in a south suburb. However,  
13 a lot of the patients were coming from the Chicago  
14 area. So the numbers that they gave were the  
15 numbers based on their zip code studies.

16 CHAIRWOMAN SAVAGE: Any other questions?

17 (No response.)

18 CHAIRWOMAN SAVAGE: Okay. George, can you  
19 please call the roll?

20 MR. ROATE: Thank you, Madam Chair.  
21 Motion made by Dr. Martell, seconded by Ms. Grundy.

22 MEMBER GRUNDY: Based on the report my  
23 vote is to deny this application, but I do want to  
24 say that there is information, key information

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1 especially with the closing of Mercy Hospital that  
2 I feel is missing that wasn't included in this  
3 report that I would like to see.

4 MR. ROATE: Thank you.

5 Mr. Kaatz.

6 MEMBER KAATZ: I vote no and my reason is  
7 from a patient safety perspective.

8 MR. ROATE: Thank you, Mr. Kaatz.

9 Dr. Martell.

10 MEMBER MARTELL: I vote no based on the  
11 staff report concerns that have been expressed  
12 regarding patient safety and referral resources  
13 and given the historical background information of  
14 referrals, as well.

15 MR. ROATE: Thank you.

16 Dr. Murray.

17 MEMBER MURRAY: I vote no based on the  
18 staff report.

19 MR. ROATE: Thank you.

20 Chairwoman Savage.

21 CHAIRWOMAN SAVAGE: And I vote no based on  
22 the State Board staff report and concur with the  
23 comments that Stacy Grundy made, as well.

24 MR. ROATE: Thank you. That's 5 votes in

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1 the negative.

2 CHAIRWOMAN SAVAGE: And so you will  
3 receive an intent to deny, and the Board staff  
4 will follow up with you.

5 MS. COOPER: Okay. Thank you.

6 CHAIRWOMAN SAVAGE: Okay. At this moment  
7 we're going to take a 30-minute break for some  
8 technical issues, and we'll come back at 10:30.  
9 So if everybody can return at 10:30.

10 (Recess taken, 9:57 a.m. to 10:41 a.m.)

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CHAIRWOMAN SAVAGE: Welcome back everyone.  
Okay. Our technical issues seem to be resolved,  
so we do have Gary on the phone, Gary Kaatz, just  
so you know.

So next up on our agenda we have  
Project H-03, 20-034 -- I'm sorry -- H-02, 20-034,  
the UroPartners Prostate Center at the Glen, the  
purchase and installation of their linear  
accelerator.

Now, may I have a motion to approve the  
UroPartners Prostate Center at the Glen to  
purchase major medical equipment?

MEMBER MURRAY: So moved.

CHAIRWOMAN SAVAGE: Thank you, Dr. Murray.  
A second.

MEMBER GRUNDY: I second.

CHAIRWOMAN SAVAGE: Thank you, Stacy Grundy.  
George, would you please present our State  
Board staff report?

MR. ROATE: Thank you, Madam Chair.

The applicant, UroPartners, LLC, is proposing  
to acquire a new linear accelerator for its existing  
physician offices located at 2634 Patriot Boulevard,

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1 Unit J, in Glenview. The anticipated completion  
2 date as stated in the application for permit is  
3 July 2nd, 2021. Project cost is \$4,980,149.

4 There were negative findings associated  
5 with this report in regard Part 1120. There were  
6 two, one being financial viability and two being  
7 reasonableness of project cost.

8 Thank you, Madam Chair.

9 CHAIRWOMAN SAVAGE: Thank you, George.

10 Paula, would you please swear in our  
11 applicants.

12 (Witnesses sworn.)

13 CHAIRWOMAN SAVAGE: And will our applicants  
14 please state your names for the court reporter,  
15 please.

16 MR. MORADO: Absolutely, members, Chair  
17 Savage. I'll go ahead and just start by saying  
18 good morning everybody. My name is Juan Morado,  
19 Jr. I'm CON counsel for this project. I'd like  
20 to thank the Board and their staff for all their  
21 assistance through this review process for this  
22 application and for the overwhelmingly positive  
23 staff report.

24 With me today for today's presentation I

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1 have William Andre, director of radiation services  
2 for UroPartners; I have Nick Radonjic, general  
3 counsel and chief operating officer for  
4 UroPartners, and Mark Silberman, my partner from  
5 Benesch Law.

6 Members of the Board, this a unique  
7 project and we recognize you don't often see  
8 applications for the acquisition of major medical  
9 equipment. In this case we are here for the  
10 acquisition of a linear accelerator to treat  
11 cancer patients, and I believe everyone would  
12 agree there is an absolute need for these  
13 services, and our presentation today is going to  
14 focus on why the application is before you and why  
15 this machine is needed to continue providing life  
16 sustaining services to the community.

17 Nick will provide you with a background on  
18 UroPartners, the history of the practice and their  
19 impact in the state in terms of patient volume.  
20 He's also going to touch on this particular  
21 facility, the types of conditions and patients  
22 treated, and finally, he will discuss the healthy  
23 and robust financial condition of the practice and  
24 how and why the practice manages its cash flow.

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1 William will discuss the existing machine  
2 and its utilization, the new proposed machine and  
3 why that one was chosen, and he's also going to  
4 describe to you the build-out required for the  
5 machine and finally, will finish up by discussing  
6 the phaseout of the existing machine.

7 Mark is going to walk through the unavoidable  
8 but limited findings, and we're confident that  
9 you're going to find that this project is well  
10 designed and will provide the necessary quality  
11 care in a way that will meaningfully impact the  
12 lives of the patients and benefit the communities  
13 that we currently serve without interrupting  
14 access.

15 So with that I would say, members of the  
16 Board, that this is a strategic decision by the  
17 practice to stay ahead of the curve and to ensure  
18 that our patients are able to consistently be  
19 provided with services that are life sustaining.

20 And with that I'm going to hand it off to  
21 Nick.

22 MR. RADONJIC: Thank you, Juan, for the  
23 introduction.

24 Ladies and gentlemen of the Board, thank

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1 you for your time and attention to this very  
2 important matter. My name is Nick Radonjic, and I  
3 am the chief operating officer and general counsel  
4 for UroPartners.

5 UroPartners was formed in 2005 to  
6 provide the greatest urological care to its  
7 patients in the state of Illinois. The practice  
8 consists of 60 urologists, five radiation  
9 oncologists, as well as four pathologists, and we  
10 serve 220,000 urological patients annually in  
11 addition to 3300 surgical candidates at our  
12 ambulatory surgery center.

13 The types of patients and the conditions  
14 that we treat include bladder cancer, testicular  
15 cancer, kidney cancer, prostate cancer, men's  
16 health, Peyronie's disease, as well as erectile  
17 dysfunction.

18 The Prostate Center at the Glen was formed  
19 in February of 2009 to serve its patients via  
20 radiation primarily prostate cancer. I'd like to  
21 discuss the financial condition of the practice.

22 The members or the physician members of  
23 this limited liability company UroPartners, LLC,  
24 received distributions at the end of the year

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1 because we have a covenant with Bank of America,  
2 our lender, that all operations and costs  
3 associated with these operations need to be met  
4 before distributions to the membership or the  
5 shareholders takes place. This transaction will  
6 be financed with Bank of America with whom we have  
7 a very long-standing relationship because it  
8 affords us the flexibility of doing so especially  
9 while these rates, interest rates remain very low.

10 The finances of the company are doing  
11 extremely well. In particular our balance sheet  
12 remains strong, the practice is healthy, and the  
13 acquisition of this machine will not have any  
14 negative impact.

15 Based on this I'd like to hand off to  
16 William to discuss the condition of the current  
17 machine and the need for a new one. Thank you.

18 MR. ANDRE: Thank you, Nick. Thank you,  
19 member of the Board, for hearing us this morning.

20 Our current machine is a Varian IX. It's  
21 11 years old now. We've worked it very hard. We  
22 do try very hard to take good care of it.  
23 However, just like anything else mechanical and  
24 electronic, things wear out and it is nearing the

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1 end of its expected life. Somewhere in the 10- to  
2 13-year range is when these machines get replaced,  
3 and we have noticed a problem with this machine.  
4 We've seen more down time having to have service  
5 people come out and fix it. We cannot fix it  
6 ourselves; we do have to use the manufacturer's  
7 service engineers to fix things and get the parts  
8 that are needed. However, that negatively does  
9 impact our patient care.

10 Radiation treatments are designed to be  
11 provided Monday through Friday. Interruptions to  
12 that treatment have a negative impact on outcomes  
13 for our patients. As such, we are trying to get  
14 ahead of the curve here, as Juan mentioned, and  
15 replace this machine before we end up with a major  
16 failure that could put us down for a couple of weeks.

17 We have done some research and looked in  
18 this issue, and we have decided on a Varian  
19 TrueBeam as our next machine. This machine offers  
20 us some advantages over our existing technology.  
21 It does have a cone-beam CT on it. It also has  
22 the ability to do stereotactic radiosurgery. Some  
23 of our patients unfortunately do have metastatic  
24 prostate cancer and benefit from having their

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1 lymph nodes treated. We are not currently able to  
2 do that. We would like to do that for our  
3 patients for continuity of care, but currently our  
4 machine is unable to do that, and we do send our  
5 patients elsewhere for that care then.

6 The cone-beam CT lets us look at the  
7 patient every day and make sure things are lining  
8 up, and again, is something that didn't really  
9 exist hardly when we purchased our original  
10 machine.

11 We also are getting in addition to the  
12 TrueBeam machine a 6 Degrees of Freedom couch.  
13 This allows us to tilt the bed the patient lays on  
14 to match the angle of the prostate. The prostate  
15 does sit between the bladder and rectum, and as  
16 such the relative fills of those organs can change  
17 the orientation of the gland, and this couch will  
18 enable us to provide more accurate and precise  
19 treatments and reduce side-effects to our patients.

20 Now, putting in a machine like this is a  
21 very complicated process. These machines do use  
22 very high-energy photons for treatment similar to  
23 an X-ray but about 1,000 times stronger. As such,  
24 to protect both staff and the public who walk past

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1 our building, we are required by state law to  
2 provide adequate shielding from the radiation.  
3 Typically we need between 4 and 6 feet of concrete  
4 that needs to be poured in addition to a very  
5 substantial base put underneath the machine to  
6 support all that weight. You can imagine that  
7 much concrete going into a building is expensive,  
8 and we have a lot of engineering things to get  
9 accomplished that all add to the cost.

10 And with that -- oh, one other thing I'd  
11 like to address is we are planning with the age of  
12 the machine to phase it out, our existing machine,  
13 and transfer care to our new machine as it will be  
14 more reliable. We can treat --

15 MR. SILBERMAN: Did we lose William?

16 MS. AVERY: We lost him.

17 MR. SILBERMAN: Juan, you'll send him a  
18 text? And in the meantime, what I will tell you  
19 is William was going to point out that there are a  
20 variety of conditions that can be treated with  
21 this machine. The primary at this facility is  
22 with regards to prostate cancer, but there are, as  
23 you see on the slide here a variety of other  
24 treatments that can be provided and are provided

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1 at other facilities, and at the end of the day  
2 this is a fundamental example of being able to  
3 increase access to care and to broaden the access  
4 to care being provided by an exceptional group,  
5 and that is one of the reasons that this project  
6 is being undertaken.

7 Juan, if you want to advance to the next  
8 slide.

9 What I wanted to do, members of the Board,  
10 is I really wanted to address three specific  
11 points with regard to the negative findings that  
12 were contained in the State Board staff report.

13 With regards to the financial ratio, there  
14 was a negative finding because UroPartners found  
15 itself -- on the historical days cash on hand it  
16 found itself slightly below the Board standard,  
17 and with regards to the current ratio they found  
18 themselves for 2019 2/100th's of a percent below  
19 the Board's standard. We don't challenge the  
20 findings of the staff; those were the correct  
21 findings, but we want to assure you that the board  
22 does have the financial wherewithal, the ability,  
23 and the desire to provide this care and to  
24 complete this project.

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1           When you're considering that financial  
2 criteria, we'd ask you to realize that, as Nick  
3 pointed out, the issues of days cash on hand was  
4 simply a result of the distributions that are paid  
5 out to the physician owners, but during the course  
6 of the year based on their covenants and their way  
7 of operating the funds are there for the operation  
8 of the project, for the operation of the practice,  
9 and for the ability to ensure providing care.

10           The other thing to please consider is this.  
11 When you look at the forward looking ratios, all  
12 of the ratios with regards to how the financials  
13 will play out, all of them were in conformance  
14 with this Board's standards.

15           Then as a final matter, there was reference  
16 to the fact and Board staff can verify that since  
17 the presentment of the State Board staff report we  
18 have provided the audited financials to be able to  
19 provide the backup documentation for all of the  
20 financial representations that were made in the  
21 application.

22           We do not believe and we hope that you  
23 will conclude that the very limited findings would  
24 provide any basis for concern to inhibit the

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1 approval of the project, especially when you  
2 consider we met all of the need criteria and all  
3 of the other financial criteria but for those two.

4 The other issue with regards to the  
5 financial criteria related to the project cost.  
6 And with regards -- actually, if you can go back  
7 for one second, Juan.

8 With regards to the costs, there were  
9 two areas, modernization, which are our  
10 construction costs, and the equipment costs. And  
11 as much as I would like to provide you a great  
12 explanation as to why that is the case, the State  
13 Board staff provided the best explanation that  
14 could be provided, and it's contained in your own  
15 staff report.

16 In the staff report it specifically points  
17 out that the cost overages for the modernization  
18 and movable equipment are inherently high due to  
19 the type of project when you consider its limited  
20 size and the vault construction and then the cost  
21 of the linear accelerator itself. When you look  
22 at the picture on the right, the vault requires a  
23 significant amount of concrete fabrication and the  
24 employee protective media, and the linear accelerator

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1 has a cost premium based on the advanced technology.  
2 That's the reason for the negative finding.

3 And, again, we don't challenge the standards.  
4 The acquisition of a linear accelerator is not a  
5 common enough project to justify its own standards,  
6 but at the same time they don't fit well within  
7 the standards that are utilized for these types of  
8 projects. There's no way that we could conform --  
9 you can't build the necessary vault for \$260 per  
10 square foot, and the linear accelerator itself  
11 exceeds the acquisition of equipment standards by  
12 three times.

13 But, members of the Board, this is the  
14 very reason that you're given the authority to  
15 approve projects when they don't comply with each  
16 and every criteria. And as I mentioned earlier,  
17 we don't want you to overlook that this project  
18 has met all of the other criteria of this Board.  
19 The only ones it hasn't met are those that it just  
20 simply couldn't comply with based on the nature of  
21 the project.

22 One other thing with regards to access of  
23 care and the importance of the care that's being  
24 provided. IDPH statistics show that prostate

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1 cancer is the number one cause of cancer in  
2 Illinois, and they talk about having 97 percent of  
3 men diagnosed with prostate cancer have a good  
4 prognosis.

5 UroPartners is very proud to be a significant  
6 part of these statistics because approximately  
7 1 out of every 5 diagnoses in the state of  
8 Illinois are patients of and being treated by  
9 UroPartners, and we'd like to continue that.

10 As a final matter, we'd just ask that when  
11 you consider this project realize there has been  
12 absolutely no opposition to this project. As Juan  
13 mentioned, this is a strategic decision to provide  
14 ensured access to care as one machine is phased  
15 out and another machine is phased in. We think  
16 it's fundamentally necessary to not only maintain  
17 but increase the access to healthcare, and we hope  
18 you will feel comfortable utilizing your authority  
19 to approve this project.

20 So with that we are happy to answer any  
21 questions that the Board or staff might have  
22 regarding our project.

23 CHAIRWOMAN SAVAGE: Okay. Do we have any  
24 questions for the applicants?

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1 MEMBER KAATZ: I do, Madam Chairman.

2 CHAIRWOMAN SAVAGE: Go ahead, Gary.

3 MEMBER KAATZ: My name is Gary Kaatz, a  
4 member of the Board. Just a couple light  
5 questions.

6 I think in your -- excuse me -- my assessment  
7 of the project is really you're replacing a very  
8 old, antiquated piece of technology with something  
9 that is pretty much state-of-the-art. Is that  
10 correct?

11 MR. MORADO: That's correct.

12 MEMBER KAATZ: And the real benefit to the  
13 patients of the Varian is that it will destroy  
14 less healthy tissue. Do I have that right?

15 MR. ANDRE: Yeah, it should be a much more  
16 precise machine. It's been proven to do that in  
17 studies, and as such we can reduce side-effects  
18 especially to the bladder and rectum.

19 MEMBER KAATZ: UroPartners, is that the  
20 name of your group? I'm sorry if I got that  
21 wrong.

22 MR. ANDRE: That's right.

23 MEMBER KAATZ: That's an impressive group,  
24 50-plus urologists. Will you also provide the

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1 physicist and the dosimetrist for this technology?

2 MS. AVERY: Hi, this is Courtney. When  
3 you're speaking, please identify yourself for the  
4 court reporter.

5 MEMBER KAATZ: I'm Gary Kaatz. I'm still  
6 asking my questions.

7 MS. AVERY: I'm sorry, Gary, the person  
8 that's responding to you.

9 MR. ANDRE: This is William Andre.  
10 UroPartners currently does provide the physics and  
11 dosimetry services for the current patients and  
12 will continue to do so with the new machine. They  
13 will undergo additional training that utilizes the  
14 new technology, as well, and that has been included  
15 in our purchase of the equipment, the training.

16 MEMBER KAATZ: Smart, smart. I think you  
17 know how complicated this is going to be in terms  
18 of building this vault, and I was surprised that  
19 even though the standard is 2400 square feet,  
20 you're really thinking that 1350 is going to be  
21 adequate for the project.

22 MR. ANDRE: This is William again. We do.  
23 We have brought in Sam Stole & Company. They have  
24 extensive experience in putting in linear

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1 accelerators in various places throughout the  
2 country. They have done measurements and  
3 preliminary drawings to help us make sure that  
4 this will fit within the space that we have.

5 Fortunately for us, the TrueBean footprint  
6 is slightly smaller than our existing, so we are  
7 able to fit it into our existing space.

8 MEMBER KAATZ: Oh, okay. That explains it.

9 And then with your group of urologists, do  
10 you have several of those individuals who are,  
11 let's say adequately trained on providing surgery  
12 on the da Vinci robot so that this really  
13 continues to be just one arm of your total  
14 portfolio of services offered for patients with  
15 prostate cancer?

16 MR. ANDRE: This is William. We have a  
17 variety of physicians. In fact, our physicians do  
18 more robotic surgeries than we do cancer treatments  
19 with radiation. We also do use watchful waiting  
20 where appropriate treatment for patients, as well  
21 as combination therapy, external beam radiation  
22 combined with LDR, low-dose radiation brachytherapy  
23 for our patients. We customize all our treatments  
24 to the patients' needs based on patient and their

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1 actual cancer.

2 MEMBER KAATZ: Last question. It's unfair;  
3 if you are uncomfortable answering it, I understand;  
4 that's fair game. What makes you more nervous  
5 about advancing this project if approved?

6 MR. ANDRE: This is William again. I'm  
7 excited about the project. I'm looking forward to  
8 about learning how to use this technology to its  
9 fullest, and I am confident in my discussions with  
10 the vendor about the capabilities of the machine,  
11 with the construction company Sam Stole that we  
12 may be using. We haven't decided yet for sure on  
13 that, but we are in the process of getting drawings  
14 done to make sure this project can go forward.

15 Working with radiation is always a risk.  
16 We constantly monitor both our staff and patients  
17 for exposure and doing everything in the right way  
18 here to make sure this project is safe and  
19 benefits our patients.

20 MR. RADONJIC: I'd like to add, as well --  
21 this is Nick Radonjic replying, as well. I'd like  
22 to share William's excitement, as well. Because  
23 we've spoken to William and a radiation oncologist  
24 who shared the enthusiasm with the new technology

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1 and the new machine, and we strongly believe that  
2 this will better and further patient care with its  
3 utilization.

4 MEMBER KAATZ: I thank you for the answers  
5 to your questions. Well thought out. Thank you.

6 CHAIRWOMAN SAVAGE: Do we have any other  
7 questions from the Board members or the State  
8 Board?

9 (No response.)

10 CHAIRWOMAN SAVAGE: State Board staff, any  
11 questions?

12 I'm sorry; whoever is speaking we can  
13 barely hear you. It could be background noise.

14 Anybody else want to say anything?

15 (No response.)

16 CHAIRWOMAN SAVAGE: Okay. I do not hear  
17 any further questions. So, George, would you  
18 please call our role?

19 MR. ROATE: Thank you, Madam Chair.

20 Motion made by Dr. Murray, seconded by  
21 Ms. Grundy.

22 Dr. Murray.

23 MEMBER MURRAY: I vote yes considering the  
24 staff report and most importantly the testimony.

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1 MR. ROATE: Thank you.

2 Dr. Martell.

3 MEMBER MARTELL: Yes, based on the staff  
4 report and the testimony and additional information  
5 provided today.

6 MR. ROATE: Thank you.

7 Mr. Kaatz.

8 MEMBER KAATZ: I vote yes based on the  
9 Board staff report, but I'm really impressed with  
10 the presentation, the testimony, the answers to  
11 the questions, and I really enjoy hearing the  
12 enthusiasm behind this project. So yes, I vote yes.

13 MR. ROATE: Thank you.

14 Ms. Grundy.

15 MEMBER GRUNDY: I vote yes based on the  
16 testimony and the staff report.

17 MR. ROATE: Thank you.

18 Chairwoman Savage.

19 CHAIRWOMAN SAVAGE: I vote yes based on  
20 the State Board staff report and the additional  
21 testimony..

22 MR. ROATE: Thank you. That's 5 votes in  
23 the affirmative.

24 - - -

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1 CHAIRWOMAN SAVAGE: Now, for other business  
2 I will call on Courtney Avery.

3 MS. AVERY: You all received a financial  
4 report. I would ask that you look over the  
5 report, and any questions you have, if you can get  
6 those questions to me, and I can get those to IDPH.

7 And the second item, Dr. Grundy, I think  
8 you have the correct 2021 meeting dates. I ask  
9 that you look over those one more time so that I  
10 can get the meeting locations and sign off on the  
11 contracts to make sure we don't have any conflicts  
12 for the 2021 meeting dates. If there are any  
13 conflicts, please mail me.

14 MEMBER MURRAY: I have a question about  
15 the meeting location. And I don't know what --  
16 again, I'll be shocked if we're able to meet in  
17 person, so I'm not quite sure -- we seem to be  
18 having problems with technology out there, so I'm  
19 just raising a question of why we're pretending  
20 we're going to the golf club.

21 MS. AVERY: Well, it's not the golf club,  
22 it's us. But I did talk to the Chair, we had a  
23 very successful experience with an outside company  
24 who set up the technology for the public hearing

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1 for Mercy Hospital, so I'm going to meet with them  
2 next week to get some projected costs in order to  
3 make sure that we don't have the problems that we  
4 experienced today. And those were at my hand.

5 MEMBER MURRAY: Okay.

6 MS. AVERY: There will be an option for  
7 the December meeting to appear in person but, of  
8 course, adhering to whatever executive order is in  
9 place for in-person meetings, but there would still  
10 be an option for the virtual meeting attendance.

11 So, again, I apologize for all the  
12 technical difficulties we had today.

13 CHAIRWOMAN SAVAGE: Does anybody have any  
14 questions about anything?

15 MEMBER KAATZ: Madam Chairman, it's Gary.  
16 I think if we can get back to the face-to-face, I  
17 think that things would be better. I find it  
18 difficult with the technology. I think it's a  
19 little more difficult to assess the projects. I  
20 would just prefer in person.

21 MEMBER MARTELL: I have found that the  
22 electronic -- and I do most of my board meetings  
23 remotely. If there's a presentation like we saw  
24 today in a PowerPoint format, that is one of the

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1 more effective. I think we really need to train  
2 individuals -- and this is going to be much more  
3 common to do more electronic. I'm going to be honest  
4 with you, I don't see pandemic numbers decreasing  
5 even with vaccination efforts well underway. I  
6 think we should encourage our presenters to do  
7 like today, I mean, just supplement with their  
8 presentation in a PowerPoint format.

9 I'm not sure -- we seem to have more problems  
10 than usual in this, but I'm hoping that the company  
11 that did the same for the Mercy Health -- you know,  
12 that public hearing was very well supported, and it  
13 was something that those of us could participate  
14 in that would allow some of our individuals who  
15 can't make it to board meetings to be able to  
16 listen into our decision making and deliberations.

17 MS. AVERY: They were really, really good.

18 CHAIRWOMAN SAVAGE: I agree, Dr. Martell.  
19 I don't see at least for a year or more for us to  
20 be probably having this pandemic get any better or  
21 enough better that we could all meet in a big room  
22 with everybody coming like we used to. But we'll  
23 see what happens for our December meeting, but  
24 every anticipation is that we're going to try to

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1 meet in person given the cases that we're going to  
2 have if at all possible.

3 MEMBER GRUNDY: I agree.

4 CHAIRWOMAN SAVAGE: Thank you. Any other  
5 questions or issues?

6 Yes, Sandy.

7 MEMBER MARTELL: Is there a way that we  
8 can send our flash drives back to -- if someone  
9 can send off an email. For those of us who are  
10 State, email seems to be the biggest technology  
11 challenge, if you could send an email where I can  
12 send back the flash drives, George, because I now  
13 have three of them in my possession, and I really  
14 don't need them.

15 CHAIRWOMAN SAVAGE: Yes, George, please  
16 tell us how to send them back.

17 MR. ROATE: I will send the address once  
18 we adjourn from the meeting. Okay?

19 CHAIRWOMAN SAVAGE: Oh, bless you.  
20 Thank you.

21 MEMBER MURRAY: Don't forget, George, many  
22 of us have no access to the State email, so use a  
23 real email that works.

24 I know this is some internal matter with

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1 the State, but let me say that even -- so let me  
2 just express this frustration for the whole Board.  
3 It would be nice to be able to participate fully  
4 in this. It's really difficult when this is a  
5 fourth email for many -- this is a unique email to  
6 this particular Board, that's the first problem.  
7 And it appears not to work aside from the problems  
8 with changing the password every 30 days.

9           So I think there's a confusion between  
10 being a State employee sitting at a State desk  
11 where this may not be as onerous, but the way we  
12 do this now, I mean, this is not an email I ever  
13 routinely look at unless we're getting close to a  
14 meeting, and even then like this time it didn't  
15 work. I mean, I got in but it was not -- I didn't  
16 have the authority to look at emails is what it said.

17           MS. AVERY: Dr. Murray, since the last  
18 administration -- and I don't know where it came  
19 from, but our Board, as you mentioned, do have the  
20 state-issued emails. So my calls -- all the hours  
21 I spent over DoIt yesterday, and I worked with  
22 DoIt and Mike Mitchell to come up with some kind  
23 of link just to click on for you all to get to  
24 your emails a lot easier. I also experience the

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1 same thing sitting at my desk and at home, so I'm  
2 hoping to have that resolved by next week.

3 MEMBER MURRAY: So, again, I don't know  
4 where we are with legal counsel. I'm sure some of  
5 this is done with the idea of legal counsel in  
6 mind, except the IT people seem to only consider  
7 the fact that people are employees. I don't mind  
8 having an email, but, again, you have to change  
9 the password every 30 days, which I would argue is  
10 onerous.

11 MS. AVERY: It is and I agree, and we have  
12 to do the same. But when I had the conversation  
13 yesterday was to ask the question can we have a  
14 link that you would just click on and be able to  
15 access your emails quickly, and there's a  
16 possibility that that can come through just  
17 accessing the website and then clicking on.

18 MEMBER MURRAY: The problem is not trying  
19 to get -- I mean, I know how to get onto  
20 Office 365. The problem is --

21 MS. AVERY: No, that's not -- so you would  
22 not have to change your email addresses -- I mean  
23 your password. Hopefully it would just be a link.

24 MEMBER MURRAY: That would help. Every

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1 six months or every year, but I just point out to  
2 me that that's a problem, and I can speculate  
3 trying to solve a problem that probably doesn't  
4 exist and doesn't get resolved anyway.

5 MEMBER GRUNDY: Courtney, I think there's  
6 a change. So when I go to my email now you have  
7 to identify your agency, and all of them say  
8 employees.

9 MS. AVERY: There's one that says partner,  
10 but I'll call you and talk to you about it.

11 MEMBER GRUNDY: Okay. I haven't seen it.  
12 Every time that I try and log in partner is not  
13 available.

14 MS. AVERY: Okay. We'll find out about it.

15 MEMBER GRUNDY: Okay.

16 MEMBER MURRAY: Then I have another  
17 question just -- not to get the answer today, but  
18 I keep bringing it up. We talked about this  
19 before, and, you know, we just finished our  
20 budget.

21 We have out-of-date standards and we are --  
22 I keep asking about a review of those, and also  
23 even more importantly an issue of planning. So  
24 originally, this Board was supposed to deal with

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1 planning. I can't remember the last time any of  
2 our budget was spent on that.

3 I would argue that the closure of Mercy,  
4 for example, was not a surprise, and I expect to  
5 see more hospitals close around the state because  
6 of COVID over the next three to five years, and we  
7 have other planning challenges even ignoring COVID.

8 So, again, I think it would be -- I would  
9 like us to have a meeting where we actually --  
10 where the agenda was to talk about that and what  
11 to do -- what we can do about planning issues.

12 MS. AVERY: Dr. Murray, at one time there  
13 was a Center for Comprehensive Planning that was  
14 put in under IDPH, and that was an unfunded mandate,  
15 and I think it was one of the recommendations that  
16 came from the task force.

17 So we are internally looking at it and  
18 trying to figure out how to do exactly what you're  
19 saying and to come up with that, but one of the  
20 big issues was that when that task force looked at  
21 it that there was no incentive for Mercy to stay  
22 open. There was no State funding for it.

23 So even though we have our planning areas  
24 and we know where there's a lack of service

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1 accessibility, we could not say, "Hey, System X,  
2 Y, and Z, we need you to put a center here; we  
3 need you to do this." But the Center for  
4 Comprehensive Health Planning, their purpose was  
5 to come together and have a state -- have a plan  
6 for the entire state.

7 So we are discussing it internally and  
8 trying to figure out what's the best way to look  
9 at that besides our inventory which dictates our  
10 planning.

11 MEMBER MURRAY: Again, I don't want to be  
12 confused. I wasn't really speaking about Mercy.

13 MS. AVERY: I just used Mercy as an  
14 example, but looking at the entire state.

15 MEMBER MARTELL: I think that that's going  
16 to be critically important as we move forward  
17 because as we have -- we're starting to see the  
18 pinch points for those of us who are in the  
19 trenches right now where hospitals have been  
20 licensed for beds but not staffed for beds.

21 So it's very hard from a planning -- I  
22 think that's the other part that we have to be  
23 cognizant of, especially, you know, as we open up  
24 more, for instance, I'm going to say ASCs or approve

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1 those through the process is that one of the areas  
2 we're kind of finding now is we might be able to  
3 provide care -- and I'm going to give a very  
4 practical example -- for COVID providing infusion  
5 therapy for the remdesivir and the dexamethasone,  
6 not inpatient for those who are not -- with  
7 monitoring after their initial start.

8           So the problem is and the challenge that  
9 we have is that we're not really -- it's really a  
10 coordinated planning system. So to echo Linda's  
11 point is I don't know where we go with that  
12 because when I look at these as one-offs each  
13 one in its entirety and we look at capacity in  
14 different areas, it's very challenging, as really  
15 the landscape has changed from inpatient to  
16 outpatient and independently held. You know, even  
17 like when we talked today a little bit about, you  
18 know, the interesting machine. And, again, a  
19 linear accelerator is so far from public health,  
20 trust me, that it was very interesting to learn  
21 about it, but, again, when they said it could be  
22 used for other treatments like breast cancer,  
23 things like that, how is that being used in the  
24 off hours. Right? That's such an expensive --

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1           MEMBER MURRAY: I want to be clear. I  
2 would like this Board to discuss this. It's not  
3 that I don't have faith in the internal discussions  
4 of IDPH. Theoretically they're busy with some  
5 other things; at least hopefully they are.

6           So I want to be clear. We don't have to  
7 replicate what used to be that didn't get funded.  
8 Planning can go on and there's something to be  
9 said for a plan that says we should be spending  
10 resources here or there even though we don't have  
11 the authority to actually spend resources.  
12 Ideally it would be great if we had authority but  
13 we don't. But I do think somebody, groups of  
14 people -- and this would not be the only  
15 organization that would do that -- thoughtfully  
16 thinking about our medical system is critical.  
17 It's going to be under strain, and I just can't  
18 accept the notion that we wouldn't spend some  
19 resources looking at this and discussing it. If  
20 the only thing we do is tell the politicians you  
21 need to put some money into planning, I mean, who  
22 knows what we'll say if we have a chance to  
23 discuss it.

24           What I'm asking for is a mechanism to be

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1 clear on the agenda a time to talk about this.  
2 And let me also suggest that when we schedule such  
3 a time on the agenda we could bring in from around  
4 the state various professionals mostly in academia  
5 who do this kind of stuff for a living and who are  
6 already involved in these planning activities. So  
7 certainly, we could be informed by their testimony  
8 and their thoughts about ways to approach this.

9 I'm not sure that requires a motion. I'm  
10 asking really the Chair to schedule some time on  
11 one of our agendas with enough advance notice --

12 MS. AVERY: Dr. Martell, I'm sorry, I was  
13 muted and you didn't hear everything I said.

14 MEMBER MURRAY: I didn't hear anything  
15 you said.

16 MS. AVERY: But, again, I totally agree  
17 with everything you're saying. And to try to  
18 recap the brilliance I just had, the Center for  
19 Comprehensive Health Planning, exactly what you  
20 described, that's what was supposed to have  
21 occurred. Again, it was under the Department of  
22 Public Health, but it was going to be funded, they  
23 thought through the HFSRB, but we couldn't do that  
24 because the law restricted it, and it was an

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1 unfunded mandate.

2           So what I'm suggesting that we do is to go  
3 ahead, finish those discussions internally, do  
4 some kind of white paper or suggestions of who  
5 should be involved, bring them to the table,  
6 probably would look like one of the Senate  
7 committees or something because we do have to make  
8 sure that it is funded, and we will continue to  
9 have that discussion and go forth, and it probably  
10 wouldn't be attached to our regular meeting  
11 agenda; we'd probably do something separate.

12           So we'll get started on that and hopefully  
13 come up with something.

14           MEMBER MURRAY: I'm thinking that would  
15 still have to be a public meeting. I don't care  
16 if it's an additional meeting.

17           MS. AVERY: It would be a public meeting.  
18 We'll just figure out who those panelists should  
19 be that you're recommending. And we do have a  
20 footprint for it because we had the Center for  
21 Comprehensive Health Planning in the law, so we  
22 would just have to go back and look at that.

23           MEMBER MURRAY: All right.

24           MS. AVERY: Thank you for your input.

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1 CHAIRWOMAN SAVAGE: Mr. Kaatz, did you  
2 have something you wanted to say?

3 MEMBER KAATZ: Madam Chairman, yes, I had  
4 two questions, but I'd like to follow up, as the  
5 Board member who is on the other side of the table  
6 on the issues for about 40 years, I can tell you  
7 that in addition to Courtney and Mike -- George, I  
8 don't think you were around back then -- but it  
9 was also added that David Carvallo and there was  
10 an attorney from the Board. And I can remember,  
11 Dr. Murray, some of the points that you're  
12 bringing up, they would come to the table and they  
13 would be pretty prepared on, and it was really  
14 tough to kind of get something by them. They were  
15 prepared on issues of incidence and prevalence,  
16 loss of population dynamics, et cetera, et cetera.

17 As a relatively new member of the Board, I  
18 look at the current rules, and the rules are so  
19 outdated it's ridiculous. So I think the first  
20 thing that maybe all of us look at when a project  
21 is presented is the staff report, do Mike and  
22 George -- through Avery do they recommend this or  
23 do they not, and then we kind of go into the meat  
24 of the project.

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1           But I think number one, the standards, or  
2           the criteria, or whatever we call them are way,  
3           way outdated. And number two, as I look at the  
4           history of this, this goes back to Public  
5           Law 93641 if I'm not mistaken, Courtney, Mike.  
6           Wasn't it a reason for us to exist to be able to  
7           demonstrate the cost savings?

8           MS. AVERY: Exactly. Not so much the  
9           planning part of it but the cost savings.

10          MEMBER KAATZ: Yeah, and I get a kick out  
11          of the fact that I think the last research that  
12          I've looked at states without certificate of need  
13          legislation were cheaper than states with  
14          certificate of need legislation, and I would just  
15          applaud any effort to go back to that as a reason  
16          why we exist. We don't seem to really spend any  
17          time on that. And they present the capital costs --  
18          don't get me wrong, they present the cookbook, but  
19          I think in terms of the cost I think that we need  
20          to get back and say what is this group doing to at  
21          least manage the growth of expense or perhaps  
22          decrease it, as other towns have done, not a lot  
23          but others have done.

24          So, Dr. Murray, I would add to what you

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1 said, but I would go back to that issue, what are  
2 we doing as far as our existence goes.

3 MS. AVERY: That goes back to a very  
4 important component, the unnecessary duplication  
5 of services as laid out in our statute. And I  
6 would have to respectfully disagree. We keep on  
7 top of the rules, the staff do, on a regular  
8 basis, and there are some things that we have to  
9 follow like RSMeans where we get our calculations  
10 from, the need calculation, which is self-reported  
11 data from those facilities. The only challenge  
12 that we really have is when a long-term care  
13 facility downsizes their bed numbers but doesn't  
14 tell us. We don't have the resources to go out  
15 and count beds and, you know, figure all of that  
16 out with the inventory --

17 MEMBER KAATZ: Sure.

18 MS. AVERY: -- but we rely on the facilities  
19 to give us that information, and when it doesn't  
20 show a need, we don't show a need. George uses  
21 the latest -- we pay for that service, which is  
22 RSMeans. When an applicant disagrees with something  
23 that is calculated, we look at it, we discuss it,  
24 and we present it to you not as a recommendation

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1 but as information.

2 So if we wanted to kind of redesign and  
3 look at how this Board should operate, then we  
4 should probably do that with a task force that  
5 changes it. Because if you recall, the name  
6 planning used to be in the title of this Board,  
7 but planning was not one of the functions of the  
8 Board by law, so that's why that was removed and  
9 the Center for Comprehensive Health Planning was  
10 created because that's a whole different service.

11 But, again, it doesn't say we can't look  
12 at it. It doesn't say that we can't do what  
13 Dr. Murray has suggested and ask for some kind of  
14 platform and collaboration with other State  
15 agencies and health systems around the state to  
16 look at those issues that Dr. Murray brought up.

17 MEMBER KAATZ: Would you agree, though,  
18 that our committee does (inaudible).

19 MS. AVERY: And that's what we do.

20 MEMBER KAATZ: You're thinking that  
21 (inaudible).

22 MS. AVERY: On a finding, no recommendation.

23 MEMBER KAATZ: Findings. I believe this  
24 Board -- I would have loved to have had the

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1 accelerator group, UroPartners, what the price of  
2 one of their treatments is compared to one of  
3 their competitors at one of the hospitals.

4 MS. AVERY: (Inaudible) you sent to us  
5 beforehand we sent directly to the applicant, and  
6 we asked those questions, and they get back to us  
7 with an answer. And if it comes up, I'm pretty  
8 sure the applicant would have no gripe about any  
9 of that.

10 MEMBER KAATZ: I think this Varian therapy --  
11 and I defer to the physicians on the Board as --  
12 as it becomes -- as that technology becomes more  
13 and more precise and you're not destroying healthy  
14 tissue, you have less patients coming back with  
15 complications of burns and other related things  
16 that really, really escalate the cost of treatment  
17 of linear accelerator therapy. And I would love  
18 to just -- okay. So you're saying I have fair  
19 game to --

20 MS. AVERY: Yes, you do.

21 MEMBER KAATZ: -- ask your cost base, what  
22 are your readmission rates perhaps?

23 MS. AVERY: Yes, and they should be  
24 prepared to answer that.

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1           MEMBER KAATZ: Good, good.

2           And, Madam Chairman, I do have two questions  
3 if I may proceed.

4           MS. AVERY: Sure.

5           MEMBER KAATZ: The first one, going to  
6 Courtney's report, I remember in the June meeting,  
7 which was my first meeting, there was a little  
8 consternation about the budget, what was in the  
9 budget, staff raises, the fact that we have a  
10 position that's not filled. And if I'm out of  
11 order on this as a new member of the Board, tell  
12 me to back off, but are those still burning  
13 issues, or are those issues that we have come to  
14 resolution on?

15           MS. AVERY: I'll give you an update. We  
16 have had a resolution. I think at the last  
17 meeting you all went into executive session, and  
18 if you don't have those minutes, we'll get them to  
19 you. They were -- was it the last meeting? Yeah,  
20 it was the September meeting. So I'll get that  
21 recording to you -- well, Debi would have to get  
22 it because I deleted it and forwarded it on to  
23 her, but we'll get that to you.

24           We just have a little bit of a snag with

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1 the hiring of the general counsel, and I hope to  
2 have that resolved this week. I misunderstood.  
3 The referral for the hire came from the governor's  
4 office, so I thought that the governor's office  
5 had vetted this person by checking references.  
6 Apparently, they thought I did but I did not; I  
7 was not instructed.

8 And now that's resolved, so today and  
9 tomorrow I'll be following up on references and  
10 reporting back to the governor's office. In the  
11 past their staff has taken the lead from posting  
12 the position, collecting résumés, interviewing --  
13 we interview as a team -- and not making an offer  
14 but saying to IDPH, "This is the person we want to  
15 hire, this the salary that we're hiring this  
16 person at," and they take over and formalize  
17 everything. That in some kind of way changed, and  
18 I wasn't alerted to that.

19 So I think that the situation will be  
20 resolved, and we should have our candidate on  
21 board by the next meeting.

22 MEMBER KAATZ: Good.

23 Last question. I have a corollary to  
24 Dr. Murray's question maybe from a different

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1 perspective. When I started in this business, I  
2 started at Rush Medical Center in the '70s. I  
3 know it's hard for anybody to believe that I'm  
4 that old -- you're supposed to be respectful. I  
5 remember -- and I'll use the current day's  
6 request. I remember when Michael Rees was  
7 operating 100 beds, Mercy had 150 or thereabouts  
8 and they were busy. And I'm sure the population  
9 on the south side is greater today than it was in  
10 the '70s, and I'm kind of appalled at the drift  
11 into for-profit medicine that is a replacement for  
12 what used to be not-for-profit medicine.

13 I don't know if it's good or bad or right  
14 or wrong, but I'm really -- I'm really as a Board  
15 member I sit back and see these for-profits moving  
16 in, and I don't know if that's -- I don't know the  
17 effect that it's had, and I think it probably goes  
18 back to --

19 MEMBER MURRAY: Well, one thing, let me  
20 just tell you that the population numbers have  
21 decreased especially in that part of the city  
22 since 1970, so don't -- that's why we need a  
23 planning function, so we can easily keep up with  
24 this stuff. Not only has the population decreased

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1 but the demographics of who lives there has  
2 changed, also.

3 But in any case, I agree with the basic  
4 point you're making, and we need to find a way to  
5 be able to discuss that. So I look forward to  
6 being told when this is going to be, when we're  
7 going to have a special meeting on it or whatever.

8 CHAIRWOMAN SAVAGE: Not in November but in  
9 the new year hopefully.

10 MS. AVERY: We'll get those dates -- we'll  
11 get those who we suggest to be at the table, we'll  
12 circulate that to Board members and we'll get  
13 it done.

14 I want to go back to something that you  
15 mentioned, Gary, about Dave Carvallo being at the  
16 table. David was an ex officio member to the  
17 Board, similar to -- well, just like Dan and  
18 Dulce. And I agree David had a lot to contribute.  
19 Some I agreed with, some I did not.

20 So when I -- by law the directors of those  
21 three agencies are to appoint an individual as the  
22 ex officio. And over the past we've had really  
23 good ex officios, and you'll notice Dan and Dulce  
24 always contribute and have something to say about

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1 different applications in a field that they know  
2 of that has to do with long-term care, that has to  
3 do with mental health. Whatever it is they give  
4 us great feedback on that.

5 IDPH usually appoints the assistant director  
6 or an equivalent. So I don't think that the David  
7 Carvallo position as it looks today is the right  
8 person to have at the table, but what I shared  
9 with them is please send us someone that can talk  
10 about programming, that can talk about statistics.  
11 We don't just want somebody to come and have a  
12 seat holder.

13 Unfortunately, we lost our last two ex  
14 officios from IDPH, and we now have the assistant  
15 director who I think will be fantastic because she  
16 has a background in local health and will probably  
17 be, if not better, just as good as David Carvallo.

18 So once we get her up and running and up  
19 to speed -- today there wasn't anything on the  
20 agenda that I thought any one of them could  
21 contribute to, but I think you'll be pleased, and  
22 we'll get that kind of support and information  
23 again. I think she's a Ph.D. I'm not sure but  
24 she will be great.

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1 MEMBER KAATZ: Thanks for the update.

2 MS. AVERY: And she has been through the  
3 orientation and everything, and she may be on the  
4 phone.

5 MEMBER KAATZ: That's all I have, Madam  
6 Chairman.

7 MEMBER MURRAY: So, Madam Chairman, I  
8 don't know if it's okay to move to adjourn if we  
9 have no other new business. I can't hear you.

10 CHAIRWOMAN SAVAGE: That would be fine for  
11 you to motion to adjourn by Dr. Murray. And may I  
12 have a second?

13 MEMBER MARTELL: Yes, I second it.

14 MS. AVERY: Thanks everyone.

15 CHAIRWOMAN SAVAGE: All right. You guys  
16 have a great week, and be safe and have a lovely  
17 Thanksgiving, and we will talk to you soon.

18 MEMBER GRUNDY: Courtney asked me to look  
19 over the tentative dates. They're fine.

20 CHAIRWOMAN SAVAGE: Okay. Thank you.

21 (Off the record at 11:40 a.m. CST)

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CERTIFICATE OF SHORTHAND REPORTER

I, Paula M. Quetsch, Certified Shorthand Reporter No. 084-003733, CSR, RPR, and a Notary Public in and for the County of Kane, State of Illinois, the officer before whom the foregoing proceedings were taken, do certify that the foregoing transcript is a true and correct record of the proceedings, that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision, and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 14th day of November, 2020.

My commission expires: October 16, 2021



\_\_\_\_\_  
Notary Public in and for the  
State of Illinois

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